[Your Name]
[Your Address]
[City, State, Zip Code]
[Phone Number]
[Policy Member ID]

[Date]

[Secondary Insurance Company Name]
[Claims Department Address]
[City, State, Zip Code]

RE: Coordination of Benefits / Secondary Claim Submission

To Whom It May Concern,

I am writing to submit a claim for secondary insurance coverage regarding services rendered on [Date of Service] by [Provider Name].

Please find the following documents enclosed for your review:

- A copy of the original itemized bill/HCFA-1500 form.
- The Explanation of Benefits (EOB) from my primary insurance carrier, [Primary Insurance Company Name].

The primary insurance has already processed this claim and paid [Amount Paid by Primary]. I am requesting that you process the remaining balance of [Remaining Balance Amount] as my secondary carrier.

Patient Information:
Patient Name: [Patient Name]
Date of Birth: [DOB]
Policy Number: [Secondary Policy Number]
Group Number: [Group Number]
Claim Number (if applicable): [Claim Number]

Please notify me if any additional information is required to complete this coordination of benefits. Thank you for your prompt attention to this matter.

Sincerely,

[Signature]
[Your Printed Name]